IN-HOME SUPPORTIVE SERVICES (IHSS)
RECIPIENT REQUEST FOR PROVIDER WAIVER

County of: _____
Notice Date: _____
Applicant Provider Name: _____
Recipient Name: _____
Recipient Case Number: _____
IHSS Office Address: _____
_____
IHSS Office Phone Number: _____

I, _____, am submitting this waiver request to _____in
(Name of County/Public Authority/Non-Profit Consortium)

order to hire the person named below to be my In-Home Supportive Services (IHSS) provider. I understand he/she has been denied eligibility to be paid from the IHSS program, due to a felony criminal conviction(s). Despite this information, I accept the responsibility for my decision, and the possible risks involved, in allowing this person to work in my home as my IHSS provider.

I have chosen to hire_____ to be my IHSS provider and acknowledge
(Applicant Provider)

that he/she has been convicted of the following crime(s):

Date of Conviction	Penal Code Section	Felony Conviction Description
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____

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AS THE IHSS RECIPIENT WHO WILL HIRE THIS PERSON TO PROVIDE IN-HOME SUPPORTIVE SERVICES, I UNDERSTAND AND AGREE TO THE FOLLOWING STATEMENTS AND ACTIVITIES LISTED BELOW

- I am hiring a person who has been convicted of the felony crime(s) listed on this form.
- I am required to keep this person's criminal information confidential and I am prohibited, by law, from sharing any part of it with any other individual or entity.
- I am completing this waiver request form, which applies only to the crime(s) listed on this form.
- If the county notifies me that this person is convicted of an additional disqualifying felony crime(s) in the future, I will be required to complete and submit another waiver if I wish to continue receiving services from this person.
- A notice will be sent to me when the county has accepted this waiver.
- The county will send a timesheet to the provider I have chosen to hire only after this waiver has been accepted.

By signing this form, I accept the responsibility for hiring the person named on this form to work in my home. I understand the County and the State of California are immune from any liability, due to the risk of any actions that may occur, because of my decision to hire him/her as my IHSS provider.

_____

Signature of Recipient or Recipient's Authorized Representative

_____ _____

Print Name Date

Without an approved waiver to hire the person named on this form, you will be responsible for paying him/her with your own money for any services provided.

Submit this form within ten (10) calendar days from the "Notice Date" listed on the upper right corner of Page 1. You may submit this form by mail or in person to your IHSS county, Public Authority, or Non-Profit Consortium office at the following address:

By mail: _____

_____

_____

In person: _____

_____

_____